



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

PATIENT CARE INJURY CLINIC PA

Respondent Name

PROPERTY & CASUALTY INSURANCE CO. OF HARTFORD

MFDR Tracking Number

M4-18-0756-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

November 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the carrier is unwilling to reimburse our facility for services rendered . . . our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: \$364.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement was based on The Physical and Occupational Therapy Specialty Guide – Part B developed by Novitas Solutions (Medicare Administrative Contract (MAC) for TX), which recommends the normal PT session time at 45-60 minutes. ."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 4, 2017 to April 7, 2017	Outpatient Hospital Services	\$364.90	\$89.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
4. Texas Labor Code §408.021(a) establishes an injured employee's entitlement health care as and when needed.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
 - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES
 - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES.

- 592 – THE RECOMMENDED ALLOWANCE HAS BEEN PROPORTIONED BASED ON THE MULTIPLE PROCEDURE RULES FOR SERVICES REVIEWED ON THIS DATE OF SERVICE OR PARTIAL PREVIOUSLY REVIEWED ON THE SAME DATE OF SERVICE.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 1115 – WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
 - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
 - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES.
 - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES.
 - 592 – THE RECOMMENDED ALLOWANCE HAS BEEN PROPORTIONED BASED ON THE MULTIPLE PROCEDURE RULES FOR SERVICES REVIEWED ON THIS DATE OF SERVICE OR PARTIAL PREVIOUSLY REVIEWED ON THE SAME DATE OF SERVICE.

Upon review of the materials presented by the respondent in support of the insurance carrier's above listed denial reasons, the submitted information was found unpersuasive and insufficient to support the carrier's reductions in payment. The carrier may not retrospectively review the necessity of services that have been preauthorized.

Rule §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The respondent asserts, "Reimbursement was based on The Physical and Occupational Therapy Specialty Guide – Part B developed by Novitas Solutions." The division notes that Novitas Solutions is a Medicare Administrative Contractor (MAC) — a private health care insurer awarded a geographic jurisdiction to process claims for Medicare beneficiaries. As a private insurer and contractor, Novitas Solutions is not the CMS.

Rule §134.203(a)(5) defines "Medicare payment policies" as "methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." The Novitas policy cited by the respondent was developed by a third party, private, independent contractor with Medicare—not CMS itself; as such, it does not meet the definition of a "Medicare payment policy" as defined in division rules.

Moreover, Rule §134.203(a)(7) states that "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program."

The Labor Code and Division rules contain specific provisions regarding utilization of services that take precedence over conflicting provisions adopted by Medicare.

Labor Code §408.021(a) entitles an injured employee to "to all health care reasonably required by the nature of the injury as and when needed." Rule §133.240(b) further requires that the carrier "shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 . . ."

Based on the above information, the respondent has failed to support a "Benefit Maximum," "Maximum Unit Value," or "Daily Maximum Allowance" had been reached or exceeded for the time period or occurrence. The carrier may not retrospectively review or apply Multiple Procedure Rules or Allowances to preauthorized services.

Review of the submitted information finds that the insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment per applicable division rules and fee guidelines.

2. This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, Rule §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:
- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83.
 - (2) The conversion factors listed in paragraph (1) . . . shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor. The applicable division conversion factor for calendar year 2017 is \$57.50.

Reimbursement for the services performed April 4, 2017 is calculated as follows:

- For CPT code 97110, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.02 is 0.459. The practice expense (PE) RVU of 0.45 multiplied by the PE GPCI of 1.009 is 0.45405. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.946 is 0.01892. The sum of 0.93197 is multiplied by the division conversion factor of \$57.50 for a MAR of \$53.59. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is \$40.53 at 4 units is \$162.12.
 - For CPT code 97140, the work RVU of 0.43 multiplied by the work GPCI of 1.02 is 0.4386. The PE RVU of 0.41 multiplied by the PE GPCI of 1.009 is 0.41369. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.946 is 0.00946. The sum of 0.86175 is multiplied by the division conversion factor of \$57.50 for a MAR of \$49.55. This code does not have the highest PE for this date. The PE reduced rate is \$37.66 at 2 units is \$75.32.
 - For CPT code 97112, the work RVU of 0.45 multiplied by the work GPCI of 1.02 is 0.459. The PE RVU of 0.49 multiplied by the PE GPCI of 1.009 is 0.49441. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.946 is 0.01892. The sum of 0.97233 is multiplied by the division conversion factor of \$57.50 for a MAR of \$55.91. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at \$55.91. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$55.84.
 - For CPT code G0283, the work RVU of 0.18 multiplied by the work GPCI of 1.02 is 0.1836. The PE RVU of 0.2 multiplied by the PE GPCI of 1.009 is 0.2018. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.946 is 0.00946. The sum of 0.39486 is multiplied by the division conversion factor of \$57.50 for a MAR of \$22.70. This code does not have the highest PE for this date. The PE reduced rate is \$16.90.
 - For CPT code 97110, the work RVU of 0.45 multiplied by the work GPCI of 1.02 is 0.459. The PE RVU of 0.45 multiplied by the PE GPCI of 1.009 is 0.45405. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.946 is 0.01892. The sum of 0.93197 is multiplied by the division conversion factor of \$57.50 for a MAR of \$53.59. This code does not have the highest PE for this date. The PE reduced rate is \$40.53 at 4 units is \$162.12.
3. The total allowable reimbursement for the services in dispute is \$472.30. This amount less the amount previously paid by the insurance carrier of \$383.02 leaves an amount due to the requestor of \$89.28. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$89.28.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$89.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	_____
Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	December 21, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.